



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SURGERY SPECIALTY HOSPITALS OF AMERICA S E HOUSTON CAMPUS 4301 VISTA ROAD PASADENA TEXAS 77504	MFDR Tracking #: M4-09-2397-01 DWC Claim #: Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE COMPANY Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Surgery Specialty Hospital of America, S.E. fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Surgery Specialty Hospital of America, S.E. is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: \$27,146.09

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed \$45,244.55 for a simple, uncomplicated discectomy on an out patient basis." "The requestor, however, has proposed a total payment of \$28,652.12 based on an alleged 'extensive review of payments...made by various Carriers from the geographical area of Texas...' However, none of that information was submitted by the requestor to give credible support to its contention that 63% of its billed charges meets the requirements of DWC Rule 134.1 or Labor Code section 413.021 as they relate to payment in the absence of a MAR." "For its part Texas Mutual no longer believes its paid amount of \$1,506.10 meets those requirements either because that amount has now fallen below what Medicare would pay for the same procedure to the same provider." "To that end Texas Mutual offered to settle this fee dispute by paying \$6,644.42 minus the previously paid \$1,506.10. The requestor rejected that proposal. "Texas Mutual's settlement offer is based on the hospital outpatient treatment guideline effective 3/1/08. DWC has indicated it believes the MARs derived from that guideline are fair and reasonable, and meet the statutory requirements of the Labor Code."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/14/2007	CAC-W10, CAC-16, 225, 426, 713, 894, 891	Outpatient Surgery	\$27,146.09	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 10, 2008.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- CAC-W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION NEEDED FOR ADJUDICATION. ADDITIONAL

INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.

- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 426 – REIMBURSED TO FAIR AND REASONABLE.
- 713 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
- 894 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.
- OUTPATIENT SERVICES ARE NOT ELIGIBLE FOR STOP-LOSS PAYMENT METHOD.
- OUTPATIENT SERVICES ARE NOT ELIGIBLE FOR STOP-LOSS PAYMENT METHOD. 225-THE OPERATIVE REPORT DOES NOT APPEAR TO SUPPORT USE OF IMPLANTS.

2. The respondent denied reimbursement based upon claim/service lacks information needed for adjudication. 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The Division finds that the denial reason is generic because it does not identify specific information needed for adjudication. For this reason, the Division finds that the 16 claim adjustment code is not supported.
3. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include" ... "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
6. Division rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Surgery Specialty Hospital of America, S.E. charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services."
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "The amount of reimbursement deemed to be fair and reasonable by Surgery Specialty Hospital of America, S.E. is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract. It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services."
- The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
- Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit "A", dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES."
- The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that "services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database."
- The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive "an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database."
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- The requestor's position statement further asserts that "amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code §413.011 as they are 'relevant to what fair and reasonable reimbursement is,' 'they are relevant to achieving cost control,' 'they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services."
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	08/25/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	08/25/2011
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.